WEST ORANGE HIGH SCHOOL

HEALTH OFFICE

51 CONFORTI AVENUE
WEST ORANGE, NJ · 07052-2829
Tele: 973-669-5301 X31521, X31522, X31524
FAX: 973-669-4760

DENISE MAKRI-WERZEN RN/MT(ASCP)CSN/HT, SCHOOL NURSE SONIA KELLEHER, BSN, CSN, RN, SCHOOL NURSE

School year 2011-2012

Dear Parent/Guardian of _____

Our health records indicate your child has an illness/condition that requires administration of medications during the school day. Therefore, the school policy dictates that you need to provide us with new and updated medical forms, filled out by your physician and guardians, at the beginning of each school year. **Please take note that all meds, including over the counter meds, require these forms be filled out each school year.**

MEDICAL ILLNESS/CONDITION: Please have your physician complete and sign the attached forms. Be sure to complete Step 2: Emergency Calls. We must have accurate phone numbers of those persons to be contacted in an emergency. It is imperative that these forms and meds be returned to the Nurses' Office as soon as possible.

DAILY OR AS NEEDED MEDICATION ADMINISTRATION: **Please bring the medication in its original container,** labeled with your child's name, physician name and phone number. Please **bring all completed medical forms and the medications to the Nurses' Office as soon as possible.**

SELF-ADMINISTRATION MEDICATON: If your child is allowed to self-administer emergency medication (i.e. Epipens, inhalers, etc) the medication must labeled with your child's name, name of medication, strength, dose, frequency, physician name with phone number and emergency contact phone numbers. If you would like to keep back up medications in our office, please bring properly labeled med containers and **completed** forms, **including *Parental Permission and Waiver* form and the *Physician Authorization for Self-Administration of Medication* form.**

The school nurses **cannot** administer any medication, or allow a student to carry medication without written authorization from you, the parent/guardian **and** the student's physician.

If at any time the information you have provided changes, including medication changes or discontinuation, you need to contact us immediately, and provide an MD note for those changes.

By the end of the school year, any medications you may have in our health office needs to be picked up by you. If the medications are not taken home, they will be discarded.

Thanking you for your cooperation and attention to this matter. Please feel free to contact us with any further questions.

Sincerely,

DENISE MAKRI-WERZEN AND SONIA KELLEHER- W.O.H.S. NURSES

THE PUBLIC SCHOOLS
WEST ORANGE, N.J. 07052

Department of Student Support Services **Health Services**

SELF-ADMINISTRATION OF MEDICATION

Dear Parent/Guardian:

Please be advised that the West Orange Board of Education has adopted a policy providing for student self-medication. The policy sets forth specific conditions under which a student may be permitted to carry and to use, in an emergency, medication.

You must provide the school nurse with written authorization for the self-administration of medication.

You must provide the school nurse with written certification from the physician of the pupil that the pupil has asthma or other potentially life-threatening illness and is capable of, and has been instructed in, the proper method of self-administration of medication.

You must sign the attached waiver which informs parents or guardians of the pupil that the district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medications by the pupil.

All documentation must be given to the school nurse before the student may be permitted to carry and use emergency medication.

Please return the attached waiver and the medical authorization form to me within fourteen days of the receipt of this letter.

_____ _____

School Nurse Date

H-96-56

THE PUBLIC SCHOOLS
Department of Student Support Services
West Orange, NJ 07052

PARENTAL PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

Student _____ DOB_____ Age _____ Grade _____

I, the parent of _____ give permission for my child to self-
(student's name)
medicate for asthma or other potentially life-threatening illness for the school year.

Signed: _____ Date: _____
Parent's/Guardian's Signature

MEDICATION WAIVER

Student _____ DOB_____ Age _____ Grade _____

This acknowledges that the district shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication.

Signed: _____ Date: _____
Parent's/Guardian's Signature

Asthma Treatment Plan

This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
Original PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION. of New Jersey

NEW JERSEY DEPARTMENT OF HEALTH & SENIOR SERVICES

(Please Print) Name	Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

HEALTHY

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

Take daily medicine(s). All metered dose inhalers (MDI) to be used with spacers.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® 100, 250, 500	1 inhalation twice a day
☐ Advair® HFA 45, 115, 230	2 puffs MDI twice a day
☐ Asmanex® Twisthaler® 110, 220	1 - 2 inhalations a day
☐ Flovent® 44, 110, 220	2 inhalations twice a day
☐ Flovent® Diskus® 50 mcg	1 inhalation twice a day
☐ Pulmicort Flexhaler® 90, 180	1 - 2 inhalations once or twice a day
☐ Pulmicort Respules® 0.25, 0.5, 1.0	1 unit nebulized once or twice a day
☐ Qvar® 40, 80	2 inhalations twice a day
☐ Singulair 4, 5, 10 mg	1 tablet daily
☐ Symbicort® 80, 160	2 puffs MDI twice a day
☐ Other	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine_____ ____minutes before exercise.

CAUTION

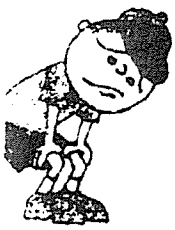
You have *any* of these:
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

Continue daily medicine(s) and add fast-acting medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Accuneb® 0.63, 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol 1.25, 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ Pro-Air ☐ Proventil®	2 puffs MDI every 4 hours as needed
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 4 hours as needed
☐ Xopenex® 0.31, 0.63, 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Increase the dose of, or add:	

➡ **If fast-acting medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY



Your asthma is getting worse fast:
- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

Take these medicines NOW and call 911.

Asthma can be a life-threatening illness. Do not wait!

☐ Accuneb® 0.63, 1.25 mg	1 unit nebulized every 20 minutes
☐ Albuterol 1.25, 2.5 mg	1 unit nebulized every 20 minutes
☐ Albuterol ☐ Pro-Air ☐ Proventil®	2 puffs MDI every 20 minutes
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 20 minutes
☐ Xopenex® 0.31, 0.63, 1.25 mg	1 unit nebulized every 20 minutes
☐ Other	

Trigger

Check all items that trigger patient's asthma

- ☐ Chalk dust
- ☐ Cigarette Smoke & second hand smoke
- ☐ Colds/Flu
- ☐ Dust mites dust, stuffed animals, carpet
- ☐ Exercise
- ☐ Mold
- ☐ Ozone alert day
- ☐ Pests - rodents cockroaches
- ☐ Pets - animal dander
- ☐ Plants, flowers cut grass, pollen
- ☐ Strong odors perfumes, cleaning products scented products
- ☐ Sudden weather change
- ☐ Wood Smoke
- ☐ Foods: _____ _____ _____
- ☐ Other _____ _____ _____ _____

This asthma treatment plan is meant to assist but not replace the clinical judgment making required to meet individual patient needs

FOR MINORS ONLY:

☐ This student is capable and has been instructed in the proper method of self-administering of the inhaled medications named above in accordance with NJ Law

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

EFFECTIVE MARCH 2008

THE PUBLIC SCHOOLS
Department of Student Support Services
West Orange, NJ 07052

To: Physicians & Parents

We are writing to ask for your cooperation as we attempt to best serve the children in our schools regarding the administration of medication during school hours.

The West Orange Public Schools' policy regarding the administration of medication during the school hours is as follows:

1) Parents & treating physicians are responsible for the diagnosis and treatment of a student's illness. The administration of prescribed medication to students during school hours will be permitted when failure to take such medicine would jeopardize the health of the student, or the student would not be able to attend school if the medicine was not available during school hours.

2) Pupils requiring medication at school must have a written statement from the family's physician that identifies the type, dosage, time schedule, purpose of the medication and possible side effects.

3) A written statement from the parent or guardian of the pupil giving permission for the school nurse to give the medication prescribed by the family physician is required.

4) Any medication to be administered during school hours must be kept in the health office.

Sincerely,

School Nurse

PARENT'S REQUEST FOR ADMINISTERING MEDICATION DURING SCHOOL HOURS

Student _____ DOB _____ Grade _____ School _____

I, the parent of _____ (student's name), request the school nurse administer the medication prescribed by _____ (Physician's Name) _____ for the period from _____ (Date) to _____ (Date).

The medication is to be furnished by me and is to be pharmacy-labeled with the name of the medicine, the amount to be given, time of day to be taken, and the expected duration of treatment. The physician's name must also be on the label. The school nurse has my permission to contact Dr. _____ at _____ (Telephone #) to the administration and effect of the medication.

_____ _____
(Parent's signature) (Date)

PHYSICIAN'S REQUEST FOR GIVING MEDICATION AT SCHOOL

Date _____

Student's Name _____ DOB _____

To: _____, School Nurse at _____ School

Rx _____

Dosage _____

Time/special circumstances of administration _____

Period of Time _____

Purpose of Medication _____

Possible side effects _____

Physician's Name _____ Date _____

Physician Signature _____

6/05 IDG